VERMONT

AGENCY OF HUMAN SERVICES

DEPARTMENT OF DISABILITIES, AGING AND INDEPENDENT LIVING

Division of Licensing and Protection
103 South Main Street, Ladd Hall
Waterbury, VT 05671-2306
http://www.dail.vermont.gov
Voice/TTY (802) 871-3317
To Report Adult Abuse: (800) 564-1612
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October 3, 2014

Ms. Maureen Ellison, Administrator
The Residence At Shelburne Bay East
185 Pine Haven Shores Road
Shelburne, VT 05482-7805

Dear Ms. Ellison:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **August 26, 2014.** Please post this document in a prominent place in your facility.

We may follow-up to verify that substantial compliance has been achieved and maintained. If we find that your facility has failed to achieve or maintain substantial compliance, remedies may be imposed.

Sincerely,

Pamela M. Cota, RN
Licensing Chief

PC:jl

PRINTED: 09/08/2014
FORM APPROVED

Division of Licensing and Protection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	1009	A. BUILDING: _____ B. WING _____	C 08/26/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE RESIDENCE AT SHELBURNE BAY EAST	185 PINE HAVEN SHORES ROAD SHELBURNE, VT 05482

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R100	Initial Comments: An unannounced onsite re-licensure survey and investigation of facility self-reports was conducted on 8/25 & 8/26/2014 by the Division of Licensing and Protection. The following regulatory deficiencies were identified:	R100	Plan of correction attached	
R135 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.5 Assessment 5.7.b If a resident requires nursing overview or nursing care, the resident shall be assessed by a licensed nurse within fourteen days of admission to the home or the commencement of nursing services, using an assessment instrument provided by the licensing agency. This REQUIREMENT is not met as evidenced by: Based upon record review and staff interviews the facility failed to assure that residents are assessed by a licensed nurse within 14 days of admission for one resident in a sample of 9 reviewed, Resident #2. Findings include: Per record review R#2 was admitted to the facility on 7/14/2014. There is no Admission Assessment present in the electronic record. In an interview at 10:45 AM, the Manager/Resident Care Director (M/RCD) acknowledged that there is no paper assessment located and that the assessment should be in the electronic record.	R135		
R136 SS=E	V. RESIDENT CARE AND HOME SERVICES	R136		

9/22/14 M Ellenwood 9/22/14

Division of Licensing and Protection
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

R135, R136, R145, + R162 POC's accepted Mthiggins/BMC 10/2/14

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R136	Continued From page 1 5.7. Assessment 5.7.c Each resident shall also be reassessed annually and at any point in which there is a change in the resident's physical or mental condition. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to assure that residents were reassessed annually for 3 residents in a sample of 9 reviewed, Residents #3, #6 and #7. Findings include: 1). Per record review Resident #3 was admitted to the facility 1/11/2012 there was an admission assessment dated 1/23/12 the next assessment was dated 12/17/14, There are no other assessments present in the record. In an interview at 10:45 AM the Manager/ Resident Care Director (M/RCD) acknowledged that there is no paper assessment located and that the assessment should be in the electronic record. 2). Per record review Resident #6 was admitted to the facility 11/19/2012 there was an admission assessment dated 11/19/12 the next assessment was dated 4/27/14, There are no other assessments present in the record. In an interview at 10:45 A the Manager/ Resident Care Director (M/RCD) acknowledged that there is no paper assessment located and that the assessment should be in the electronic record. 3). Per record review Resident #7 was admitted to the facility 10/10/2008 there was an admission assessment dated 10/14/12 the next assessment	R136		

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	1009	A. BUILDING: _____ B. WING _____	C 08/28/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE RESIDENCE AT SHELBURNE BAY EAST	185 PINE HAVEN SHORES ROAD SHELBURNE, VT 05482

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R136	Continued From page 2 was dated 12/17/14, There are no other assessments present in the record. In an interview at 10:45 A the Manager/ Resident Care Director (M/RCD) acknowledged that there is no paper assessment located and that the assessment should be in the electronic record.	R136		
R145 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.9.c (2) Oversee development of a written plan of care for each resident that is based on abilities and needs as identified in the resident assessment. A plan of care must describe the care and services necessary to assist the resident to maintain independence and well-being; This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to assure that a written plan of care was developed for one resident in a sample of 9, Resident #8, who was experiencing pain. Findings include: Per record review R #8 was experiencing severe back pain. The pain began on 6/9/14 and was described as an 8-10 on a scale of 10. There is no Pain or Alteration in Comfort care plan for the pain which was diagnosed as a Compression Fracture of a Lumbar Vertebrae when she was sent to the FAHC ER (Fletcher Allen Healthcare Center Emergency Room) on 6/11/14. There was no fall recorded or reported and the resident stated she didn't know what had happened to cause the back pain/injury. In an interview on 8/26/14 at 11:50 AM the M/RCD stated that the	R145		

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R145	Continued From page 3 care plan should be in the electronic record.	R145		
R162 SS=E	V. RESIDENT CARE AND HOME SERVICES 5.10 Medication Management 5.10.c. Staff will not assist with or administer any medication, prescription or over-the-counter medications for which there is not a physician's written, signed order and supporting diagnosis or problem statement in the resident's record. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to assure that there were complete Physician's Orders for all medications for 3 residents in a sample of 9, Residents #1, #2, and #4. Findings include: 1). Per record review on 8/28/14 the physician's orders for 2 residents receiving PRN (as needed) medications did not include an indication for use, as follows: A). Resident #1 has an order for "Ibuprofen 400mg By mouth (PO)- PRN. Take 2 tabs (total 400mg) by mouth every 4 hours as needed not to exceed 6 doses in 24 hours." B). Resident #2 has an order for "Ibuprofen 400mg By mouth (PO)- PRN. Take 2 tabs (total 400mg) by mouth every 4 hours as needed not to exceed 6 doses in 24 hours." 2). Per record review Resident #4 has orders for: "Advil (Ibuprofen) 400mg By mouth (PO)-PRN Ibuprofen 400mg by mouth every 4 hours PRN for pain" "Tylenol (acetaminophen) 650mg By mouth	R162		

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R162	Continued From page 4 (PO)-PRN Tylenol 650mg by mouth q8hours PRN for pain/fever." There is no direction for determining when to use which PRN medication and how to determine the use of the second medication in combination.	R162		

The measures that will be put in place or systemic changes to ensure that the deficient practice will not recur are as follows:

R135

5.5 assessments

R#2-admission assessment- Admission assessment completed/signed off by RN on 8/28/14

Plan:

Upon admission, each resident will have a check sheet which specifies all duties which need to be performed upon admission (see attached-form stipulates that licensed nurse must complete assessment with 14 days). Sheet will be used as an auditing tool and will need to be submitted to HSD or covering charge nurse to affirm completion prior to day 14.

Nurse responsible for completion of assessment is not currently employed within community; remainder of nursing Staff educated of new procedure and existing policy that admission assessments must be completed with 14 days of admission.

Expected implementation/education completed: 8/28/14. Auditing process ongoing

R136

Reassessment: annual/change of condition

Residents #3,#6,#7

#3- Resident Assessments were completed upon admission 1/10/12 and next assessment was done 12/17/13; not 12/17/14 as indicated in report (as this date has not yet occurred)

#6- Initial resident assessment completed 11/19/12; sweeping Audit in April 2014 brought to light that assessment was not completed by 12/19/13. Assessment was completed at time of discovery (4/27/14).

#7-There was a resident assessment dated 11/2/12; next assessment due 11/2/13. There is no assessment dated 12/17/14 as indicated in report (as this date has not yet occurred). Concur that resident assessment was 61 days overdue. Resident deceased as of 1/1/2014.

No nurses responsible for errors are still employed in community for follow up or subsequent corrective action. Enforced importance of compliance with annual assessments with current nursing staff to maintain The Residence at Shelburne Bay policy of performing assessments annually and upon change of condition.

Plan:

Annual resident assessments will be monitored in Point Click Care UDA assessment report by RCD or covering charge nurse on a biweekly basis to ensure that no resident assessments are overdue

Expected Implementation/education completed: Education 9/22/14. Auditing will be ongoing

R145

Overseeing development of a written care plan

#8-Resident has since passed away

Plan:

In the future, ongoing monitoring will be in place. Nurse report sheets will be reviewed daily (M-F) to ensure that all temporary/chronic problems are added to problem list which includes appropriate measures for follow up such as updating the care plan (see attachment). Actions taken are to be discussed/confirmed at following morning nurse meeting to ensure appropriate follow though has occurred. Check sheets will be monitored to verify compliance.

Nurse directly responsible for completing care plan is no longer employed in community

Expected Implementation/education completed: Nurse Education 9/21/14. Morning discussions implemented 9/22/14. Monitoring ongoing.

R162

Medication management

#1,#2,#4-Indicated Ibuprofen/Tylenol orders have been clarified to reflect indication of use or discontinued as appropriate. (These were all derived from standing orders)

New standing orders for analgesic put in place to rectify issue

Standing order is as follows:

Tylenol 650mg PO Q 4H PRN complaints of pain or fever above 100.4 (Do not exceed 3000mg in 24 hours).

Plan:

Nurses educated to double check orders to ensure that they contains all required information including that PRN orders must indicate reason for use.
Ibuprofen is no longer on standing orders and is to be ordered on a case by case basis per resident request/MD instruction for specific complaints which must be indicated in order to eradicate the possibility of ambiguity regarding which analgesic a med tech should administer .

Community in process of sending standing orders to primary care physicians to supplant current standing orders

Expected implementation/education completed: Initiated 8/27/14. Education to nursing staff 8/27/14. Audit then performed for all existing PRN Tylenol and Ibuprofen orders in community; nursing staff continuing to contact physicians to clarify and/or d/c ambiguous orders as appropriate.

Admission Overview

Please initial as you complete tasks

Family facilitator to obtain the following prior to admit: Insurance Cards ☐
Code Status ☐ POA Documents ☐ Living Will if applicable ☐
Admit date: sheet to be turned in to RCD by:

	Safety		**Nursing Responsibility (RN/LPN)**
	Review Fire Emergencies	Complete head to toe assessment	
	Review Evacuation Process		Review Dietician
	Review use of Pendant		Review VNA Foot Clinic
	Assign Pendant		Review Pharmacy Services
	Review Phone off Hook		Review OTC medication policy
	Review Pull Cords	**Determine needs for:**	
	Provide list of care ext.		Showering/ General Hygiene
	Resident demonstration of appropriate response (i.e. use of pendant & phone)		Toileting
			Laundering
			Linens
Care Staff Responsibility			Adaptive equipment needed
	Welcome and Introduction		**Assessments upon admit**
	Completion of intake form		Complete head to toe assessment
	Review of care ext.		Falls Risk Assessment
	Tour of the unit		Mini Mental Exam
	Introduction to Act. Coord		AIMS Assessment
	Review Meal Times, need for escorts/ NOC checks		****Resident assessment (must be completed by nurse/signed off by RN by day 14 s/p admit)**
	Nurse eval need for:	**PCC**	
	Psychoactive Careplan		Obtain wait list # from business office
	PT/OT Referral/gaitbelt?		Add resident to PCC
	1:1 Transition Assistance		Do pages 1-2 on Resident Assessment
	Safety Checks		Develop initial service plan
	Other		Transcribe MD orders
	Enhanced Services Overview		Transcribe medical diagnosis
	24 hour dining notice		Add admission progress note
	Transportation Overview	**Communication**	
	Schedule Family Meeting (45 days) _____		Provide detailed communication to staff
			Send insurance cards and med list to Health Direct
	Review Resident Rights		Print MAR/Care plan
	Provide dining with any dietary orders		

****This sheet must be turned in to RCD prior to day 14 for review. Corrective action will be implemented for any incomplete Resident assessments****

Floor_____ Date_____

Resident name	problem	Assess	MD	family	Res/fam svc	ESP	PT/OT/ST	Careplan updated	f/u needed?

M-F: Problem list to be reviewed daily with RCD (or covering) to ensure appropriate f/u has occurred